Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults.

Bibliographic Source(s)

Guideline Development Panel for the Treatment of PTSD in Adults. Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults. Washington (DC): American Psychological Association; 2017 Feb 24. 119 p. [148 references]

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition
YES	Multidisciplinary Group
YES	Methodologist Involvement

▮▮▮▮▮	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
▮▮▮▮▮	Search Strategy
▮▮▮▮▮	Study Selection
▮▮▮▮▯	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
▮▮▮▮▮	Grading the Quality or Strength of Evidence
▮▮▮▮▮	Benefits and Harms of Recommendations
▮▮▮▮▯	Evidence Summary Supporting Recommendations
▮▮▮▮▯	Rating the Strength of Recommendations
▮▮▮▮▯	Specific and Unambiguous Articulation of Recommendations
▮▮▮▮▯	External Review
▮▮▮▯▯	Updating

Recommendations

Major Recommendations

Psychotherapy

For adult patients with posttraumatic stress disorder (PTSD), the panel strongly recommends that clinicians offer one of the following psychotherapies/interventions (listed alphabetically):

- Cognitive behavioral therapy (CBT)*
- Cognitive processing therapy (CPT)
- Cognitive therapy (CT)
- Prolonged exposure therapy (PE)

(Strength of Recommendation: Strong For)

For adult patients with PTSD, the panel suggests that clinicians offer one of the following psychotherapies/interventions (listed alphabetically):

- Brief eclectic psychotherapy (BEP)
- Eye movement desensitization and reprocessing therapy (EMDR)
- Narrative exposure therapy (NET)

(Strength of Recommendation: Conditional)

For adult patients with PTSD, there is insufficient evidence to recommend for or against clinicians offering

the following psychotherapies/interventions (listed alphabetically):

- Relaxation (RX)
- Seeking Safety (SS)

(Strength of Recommendation: Insufficient)

Pharmacotherapy

For adult patients with PTSD, the panel suggests that clinicians offer one of the following (listed alphabetically):

- Fluoxetine
- Paroxetine
- Sertraline
- Venlafaxine

(Strength of Recommendation: Conditional)

There is insufficient evidence to recommend for or against clinicians offering the following medications (listed alphabetically) for treatment of adults with PTSD:

- Risperidone
- Topiramate

(Strength of Recommendation: Insufficient)

Comparative Effectiveness

For adult patients with PTSD, the panel recommends clinicians offer either prolonged exposure or prolonged exposure plus cognitive restructuring when both are being considered. (Strength of Recommendation: Strong For)

For adult patients with PTSD, the panel recommends clinicians offering either venlafaxine extended release (ER) or sertraline when both are being considered.** (Strength of Recommendation: Strong For)

For adult patients with PTSD, the panel suggests clinicians offer CBT rather than relaxation when both CBT and relaxation are being considered. (Strength of Recommendation: Conditional For)

For adult patients with PTSD, the panel suggests clinicians offer prolonged exposure therapy rather than relaxation when both prolonged exposure therapy and relaxation are being considered. (Strength of Recommendation: Conditional For)

For adult patients with PTSD, the panel concludes that the evidence is insufficient to recommend for or against clinicians offering Seeking Safety versus active controls. (Strength of Recommendation: Insufficient)

*The Research Triangle Institute-University of North Carolina Evidence-based Practice Center (RTI UNC) review refers to this as CBT-mixed therapy. CBT-mixed is a category that includes interventions using aspects of CBT that do not fit neatly into the other CBT categories. It will be referred to in the guideline as CBT.

**The recommendation for the comparison between venlafaxine ER vs. sertraline is different than the recommendation for Seeking Safety vs. active controls, even though there is moderate evidence of no difference between the two treatments being compared for both comparisons (i.e., venlafaxine ER vs. sertraline and Seeking Safety vs. active controls). The reason the recommendations are different for venlafaxine ER vs. sertraline than for Seeking Safety vs. active controls is that the panel made a conditional recommendation for venlafaxine compared to no intervention and a conditional recommendation for sertraline compared to no intervention but did not make any recommendations for Seeking Safety compared to no intervention or active controls compared to no intervention because there was insufficient/very low evidence. In other words, the panel believed that because there was evidence that both venlafaxine and sertraline had demonstrated efficacy compared to inactive intervention, it was reasonable to recommend either treatment when both are being considered. However, because neither Seeking Safety nor active controls had demonstrated efficacy compared to no intervention, the panel concluded that evidence was insufficient to recommend for or against either treatment.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Posttraumatic stress disorder (PTSD)

Guideline Category

Assessment of Therapeutic Effectiveness

Treatment

Clinical Specialty

Family Practice

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

To provide recommendations on psychological and pharmacological treatments for posttraumatic stress disorder (PTSD) in adults

Note: Although of considerable importance in the treatment of PTSD, this guideline does not address complementary or alternative treatments, assessment and screening of PTSD, subthreshold PTSD, PTSD prevention, PTSD treatment in children, dose/timing/duration of treatment, or cost.

Target Population

Adults with posttraumatic stress disorder (PTSD)

Interventions and Practices Considered

Psychotherapy

- Cognitive behavioral therapy (CBT)

Cognitive processing therapy (CPT)
Cognitive therapy (CT)
Prolonged exposure therapy (PE)
Brief eclectic psychotherapy (BEP)
Eye movement desensitization and reprocessing (EMDR)
Narrative exposure therapy (NET)

Pharmacotherapy

Fluoxetine
Paroxetine
Sertraline
Venlafaxine

Note: There was insufficient evidence to recommend for or against the following interventions: Seeking Safety, relaxation, risperidone, topiramate

Major Outcomes Considered

- Post-traumatic stress disorder (PTSD) symptom reduction
- Serious harms (adverse events)
- Remission (no longer having symptoms)
- Loss of PTSD diagnosis
- Quality of life
- Disability or functional impairment
- Prevention or reduction of comorbid medical or psychiatric conditions
- Adverse events leading to withdrawals (treatment discontinuation)
- Other adverse events
- Burdens

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Scope of the Guideline

This guideline is based on a systematic review of the evidence on treatment of post-traumatic stress disorder (PTSD), *Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder (PTSD)*, sponsored by the Agency for Health Care Research and Quality (AHRQ) and conducted by the Research Triangle Institute-University of North Carolina Evidence-Based Practice Center (RTI-UNC EPC) (see the "Availability of Companion Documents" field).

The guideline addresses the following Key Questions:

What is the efficacy of psychological and medication treatments for adults with PTSD, compared to

no treatment or to inactive treatments?
What is their comparative effectiveness (i.e., psychological treatments compared to other psychological treatments, medication treatments compared to other medication treatments, and psychological treatments compared to medication treatments)?
Which treatments work best for which patients? In other words, do patient characteristics or type of trauma modify treatment effects?
Do serious harms of treatments or patient preferences influence treatment recommendations?

Literature Search Strategy

The systematic review authors searched MEDLINE®, the Cochrane Library, the PILOTS database, International Pharmaceutical Abstracts, CINAHL®, PsycINFO®, Web of Science, and EMBASE for English-language and human-only studies published from January 1, 1980, to May 24, 2012. Searches were run by an experienced information scientist/EPC librarian and were peer reviewed by another information scientist/EPC librarian. They manually searched reference lists of pertinent reviews, included trials, and background articles on this topic to look for any relevant citations that their searches might have missed.

The authors searched for unpublished studies relevant to this review using ClinicalTrials.gov, the Web site for the U.S. Food and Drug Administration, and the World Health Organization's International Clinical Trials Registry Platform.

They developed eligibility (inclusion and exclusion) criteria with respect to PICOTS (populations, interventions, comparators, outcomes, timing, settings), and study designs and durations for each KQ. They included studies enrolling adults with PTSD based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria that evaluated one or more of the included psychological or pharmacological interventions compared with wait list, usual care (as defined by the study), no intervention, placebo, or another psychological or pharmacological intervention. The following psychological treatments were included: brief eclectic psychotherapy; cognitive behavioral therapy (CBT), such as cognitive processing therapy (CPT), cognitive therapy (CT), cognitive restructuring (CR), exposure-based therapies, and coping skills therapies; eye movement desensitizing and reprocessing (EMDR); hypnosis or hypnotherapy; interpersonal therapy; and psychodynamic therapy. The following pharmacological treatments were included: selective serotonin reuptake inhibitors (SSRIs) (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline), serotonin and norepinephrine reuptake inhibitors (SNRIs) (desvenlafaxine, venlafaxine, and duloxetine), other second-generation antidepressants (bupropion, mirtazapine, nefazodone, and trazodone), tricyclic antidepressants (imipramine, amitriptyline, and desipramine), alpha-blockers (prazosin), atypical antipsychotics (olanzapine and risperidone), benzodiazepines (alprazolam, diazepam, lorazepam, and clonazepam), and anticonvulsants/mood stabilizers (topiramate, tiagabine, lamotrigine, carbamazepine, and divalproex).

Studies were required to assess at least one of the following outcomes: PTSD symptoms, remission (no longer having symptoms), loss of PTSD diagnosis, quality of life, disability or functional impairment, return to work or to active duty, or adverse events. Eligible settings included outpatient and inpatient primary care or specialty mental health care settings, community settings (e.g., churches, community health centers, rape crisis centers), and military settings. The authors included randomized controlled trials (RCTs) of at least 4 weeks in duration for KQs 1 through 5. For KQ 6, on harms, the following were also eligible: nonrandomized controlled trials of any sample size, prospective cohort studies with a sample size of at least 500, and case-control studies with a sample size of at least 500.

Two members of the research team independently reviewed all titles and abstracts (identified through searches) for eligibility against their inclusion/exclusion criteria. Studies marked for possible inclusion by either reviewer were retrieved for full-text review. Two members of the team independently reviewed each full-text article for inclusion or exclusion. If the reviewers disagreed, they resolved conflicts by discussion and consensus or by consulting a third senior member of the team.

Impact of New Trials on Recommendations

The systematic review that was used as the evidence base for this guideline included trials that had been

published prior to May 24, 2012. To determine whether the panel recommendations based on that evidence would hold up in the face of new evidence published since that time, the panel conducted a revised search, to identify trials published between May 25, 2012 and June 1, 2016.

Refer to the original guideline document and systematic review (see the "Availability of Companion Documents" field) for additional information on evidence search and selection.

Number of Source Documents

- Number of studies (articles) included in qualitative synthesis of systematic review: 92 (101)
- Number of studies included in quantitative synthesis of systematic review: 77
- Number of articles included in updated literature review: 20

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Definitions of the Grades of Overall Strength of Evidence

Grade	Definition
High	High confidence that the evidence reflects the true effect. Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Moderate confidence that the evidence reflects the true effect. Further research may change confidence in the estimate of the effect and may change the estimate.
Low	Low confidence that the evidence reflects the true effect. Further research is likely to change confidence in the estimate of the effect and is likely to change the estimate.
Insufficient	Evidence either is unavailable or does not permit estimation of an effect.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Assessing Strength of Evidence

Strength of Evidence (SOE) rating of randomized trials by the Agency for Healthcare Research and Quality (AHRQ) Evidence-Based Practice Centers (EPCs) is the assessment of a body of evidence (i.e., the aggregated data for a particular intervention for a particular outcome from more than one study. For instance, the findings on the effects of cognitive processing therapy on posttraumatic stress disorder [PTSD] symptoms reduction, based on the four studies of medium risk of bias or less that were included in the meta-analysis, is a body of evidence) based on four major criteria, of which *risk of bias* (defined and discussed in the original guideline document) is the first, followed by *consistency*, *directness*, and *precision*. *Consistency* is the degree to which the direction of effect is the same or different in the studies included in a body of evidence. If several studies find that an intervention leads to a reduction in PTSD symptoms but other studies find that the intervention leads to an increase in PTSD, the body of

evidence is rated as inconsistent. *Directness* is the degree to which the evidence linking the effect of an intervention to an outcome is based on: 1) the true health outcome, as opposed to a surrogate marker of that health outcome and 2) head-to-head comparison of individual interventions as opposed to comparison of two separate bodies of evidence. For example, if a body of evidence in which the effect of an intervention on the outcome "loss of PTSD diagnosis" were to include only data on PTSD symptom reduction, it would be rated as indirect. *Precision* of an estimate is based on the width of the confidence interval around the estimated summary effect size in a meta-analysis; the narrower the confidence interval, the greater the precision. A more precise estimate provides stronger evidence that the estimated magnitude of effect for the results of an intervention is the true effect. If two clinically distinct conclusions (e.g., that an intervention is better than inactive control and that an intervention is worse than inactive control) are possible based on a wide confidence interval, the body of evidence is rated as imprecise.

Strength of evidence rating of randomized trials by AHRQ EPCs also depends on three additional minor domains: *dose-response relationship* (evidence that higher "doses" of an intervention are associated with larger effects represents higher strength evidence), *magnitude of an effect* (large-magnitude effects represent higher strength evidence), and *publication bias* (evidence that unpublished studies were not included in summary effect estimates lowers the strength of evidence). For the Research Triangle Institute-University of North Carolina Evidence-based Practice Center (RTI-UNC) Systematic Review, two researchers conducted strength of evidence assessments for each body of evidence (which could include one or more studies). Each was rated as high, moderate, low, or insufficient/very low strength. Disagreements between the two raters were resolved by consensus or by the assessment of another experienced researcher.

The goal of grading the SOE is to determine the confidence that the estimated effect of an intervention is the true effect, something that has broad implications for reliability of the findings and the public's confidence in them. For high strength evidence, "future research is very unlikely to change confidence in the estimate of the effect" per Owens et al. (2010). Appendix G of the RTI-UNC review (see the "Availability of Companion Documents" field) describes the strength of evidence criteria and questions (items) used to assess those criteria. Strength of evidence for all bodies of evidence used in the development of the current guideline is shown in the Evidence Profiles, included in Appendix C of the original guideline document (see the "Availability of Companion Documents" field). A description of Evidence Profiles is found in the original guideline document.

Impact of New Trials on Recommendations

For each of the original recommendations matched by one or more of the trials identified by the new search, the panel subcommittee assessed whether the recommendation was likely to change on the basis of the new evidence or was unlikely to change. To make this decision, the panel compared the effect sizes (Cohen's d) for PTSD symptom reduction in the new trials for that recommendation to the standard mean differences (SMD) for PTSD symptom reduction from the systematic review, for that same recommendation. Cohen's d for the new trials was based on the effect sizes for PTSD symptom reduction reported in the published articles. If Cohen's d was not reported in the article, it was calculated, based on standard formulas. Because confidence intervals around the estimated effect sizes were rarely reported, the panel used the sample size in each study as a proxy for the precision (i.e., confidence interval width) of the effect size precision.

As in the deliberations by the full panel for the decision tables, effect sizes were characterized initially as small (0.2), medium (0.5) and large (0.9), but were categorized as small or medium/large (i.e., medium and large effect sizes were considered together as one category) for decision making about the magnitude of benefits. All effect sizes for efficacy comparisons (i.e., active intervention compared to a control comparator) were reported as positive numbers if the result favored the active intervention (i.e., if the group randomized to active intervention had greater PTSD symptom reduction than those randomized to controls). Negative effect sizes indicate that the control group had greater reductions in PTSD symptoms than those in the active intervention group. For comparative effectiveness comparisons in which two active interventions were compared, effect sizes were reported as positive when the

participants allocated to the first listed intervention had greater improvement in PTSD symptom reduction than those who were allocated to the second intervention.

The panel did not have the time or resources to assess risk of bias for the newly identified individual trials. The panel members recognized that this lack of risk of bias assessment placed significant bounds on the certainty with which conclusions could be drawn since any one or more of the new trials might be rated high risk of bias and therefore not included in future meta-analyses. However, if all of the effect sizes for a group of trials that matched to a recommendation were on the same side of the null (i.e., favoring one intervention versus a comparator) or if all of the effect sizes were not only on the same side of the null but were of comparable magnitude, then even if one or more of the trials were rated high risk of bias, the conclusions would be unlikely to change.

Refer to the original guideline documentation for additional information about the development and use of evidence profiles and decision tables, rating of aggregate/global strength of evidence, assessing magnitude of benefits and harms/burdens, assessing.

Methods Used to Formulate the Recommendations

Expert Consensus (Delphi)

Description of Methods Used to Formulate the Recommendations

Process and Method

At the outset, panel members discussed a range of relevant outcomes and determined which were most critical for deciding whether to recommend or not recommend a treatment through a modified Delphi survey. The panel decided that posttraumatic stress disorder (PTSD) symptom reduction and serious harms/adverse events were the most critical outcomes and that remission (no longer having symptoms), loss of PTSD diagnosis, quality of life, disability or functional impairment, prevention or reduction of comorbid medical or psychiatric conditions, adverse events leading to withdrawals (treatment discontinuation), and other adverse events, and burdens were important though not critical.

The primary evidence base for the present guideline was the systematic review, *Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder (PTSD)*, produced by the Research Triangle Institute-University of North Carolina Evidence-Based Practice Center (RTI-UNC EPC) which followed the protocol set forth by the Institute of Medicine for conducting systematic reviews. The comprehensive and transparent systematic review addressed psychological and pharmacological treatments for PTSD. The trials included in the systematic review included samples that, as a whole, were broadly diverse in terms of gender, race, ethnicity and type of trauma.

The American Psychological Association's (APA's) Advisory Steering Committee for Development of Clinical Practice Guidelines (ASC) issued a call for panel member nominations (including self-nominations) for individuals from a variety of backgrounds (consumer, psychology, social work, psychiatry, general medicine) with content and treatment knowledge or methodological expertise.

The panel considered four factors as it drafted recommendations: 1) overall strength of the evidence; 2) the balance of benefits vs. harms/burdens; 3) patient values and preferences; and 4) applicability. Based on the combination of these factors, the panel made a strong or conditional recommendation for or against each particular treatment or made a statement that there was insufficient evidence to be able to make a recommendation for or against. The panel used a tool called a decision table to document its decision-making process for each recommendation. Copies of the decision tables are available in Appendix D of the original guideline document (see the "Availability of Companion Documents" field).

Decision-making Regarding Treatment Recommendations

On the basis of the ratings of these four factors (strength of evidence, balance of benefits versus

harms/burdens, patient values and preferences, and applicability) the guideline panel then made a decision regarding its recommendation for a particular treatment or comparison of treatments. The scale for recommendations included the following: strong for, conditional for, insufficient evidence, conditional against, strong against. Panel members were able to reach consensus regarding the strength of recommendation given to each treatment in most cases but, for several, a vote was required. When a vote was called, the tally was included on the corresponding decision table found in Appendix D in the original guideline document.

Rating Scheme for the Strength of the Recommendations

The scale for recommendations included the following: strong for, conditional for, insufficient evidence, conditional against, strong against.

Cost Analysis

Treatment costs were not considered in the formulation of the panel's recommendations.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

External Review Process

This document was submitted for feedback to the American Psychological Association (APA) Advisory Steering Committee (ASC) for Development of Clinical Practice Guidelines. The comprehensive comments of ASC members were given a detailed review and response and the guideline draft was modified based on that feedback. The draft was subsequently posted on the APA web site (October 5-December 4, 2016) and public feedback was solicited for 60 days. More than 890 responses were received. These were catalogued by comment topic and by theme and the main document was revised based on that feedback. In addition to the document text, four specific recommendations were modified following the public comment period. While the systematic review reported findings for exposure therapy, commenters noted that the majority of the research reviewed was specific to prolonged exposure. The panel undertook an analysis and determined that it was more appropriate to call the intervention prolonged exposure (PE) specifically. Furthermore, three decision tables were revisited resulting in a change regarding topiramate (now insufficient evidence to make a recommendation) and an acknowledgment of increased uncertainty in the stability of the conditional recommendations for eye movement desensitization and reprocessing therapy (EMDR) and narrative exposure therapy (NET) as future meta-analyses may result in one or both treatments receiving a strong recommendation.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate treatment of post-traumatic stress disorder

Refer to the original guideline document for assessment of benefit versus harm for each intervention.

Potential Harms

- Panel members considered events such as the need for hospitalization secondary to risk for suicide or a suicide attempt as a serious adverse event and then identified additional harms such as medication side effects. Harms were differentiated from burdens. Burdens refer to encumbrances associated with treatment (i.e., time spent, homework/need to practice, cost, inconvenience) rather than as damages.
- In general, many of the identified harms and burdens are found in response to many, more general, psychosocial treatments (e.g., the potential for short-term exacerbation of symptoms [harm] or the time necessary for multiple therapy sessions [burden]).
- There was low strength of evidence that prolonged exposure therapy is associated with increases in posttraumatic stress disorder (PTSD) symptoms in some patients.

Refer to the original guideline document for assessment of benefit versus harm for each intervention.

Qualifying Statements

Qualifying Statements

- This guideline is intended to be aspirational and is not intended to create a requirement for practice. It is not intended to limit scope of practice in licensing laws for psychologists or for other independently licensed professionals, nor limit coverage for reimbursement by third party payers.
- The term guideline refers to statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists or other independently licensed professionals. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. In contrast, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists and other professionals. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists and other professionals.
- The recommendations made by the APA Posttraumatic Stress Disorder (PTSD) Guideline Development Panel (GDP) were developed after careful review of the evidence. The GDP endorses the following statement from the British National Institute for Health and Care Excellence: "When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline is not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian."
- The guideline has some limitations. Gaps in the current empirical literature regarding treatment comparisons, evaluation of moderators of treatment effects, inclusion of participants with comorbidities, measurement of potential side effects and harms, and assessment of important

outcomes and the timing of their assessment all need to be addressed to answer important clinical questions. Additionally, methodological improvements that minimize attrition/dropout, decrease missing data and ensure sufficient power will improve the quality of the findings and hence the possible conclusions that can be drawn. Finally, the panel did not have data on which to make recommendations for some treatments in use because they arise from traditions with non-randomized controlled trial (RCT) research practices or the quality of the research base has not been subjected to the level of critical appraisal of systematic review.

Implementation of the Guideline

Description of Implementation Strategy

Considerations for Treatment Implementation

These recommendations for posttraumatic stress disorder (PTSD) treatments were developed using rigorous processes promulgated by the Institute of Medicine and based on evidence from a strong and transparent systematic review conducted by the Research Triangle Institute-University of North Carolina Evidence-Based Practice Center (RTI-UNC EPC) (see the "Availability of Companion Documents" field). In keeping with the tripartate evidence-based approach that has been the American Psychological Association (APA) standard (consisting of research evidence, clinician input and judgment, and patient preference and values), panel members recognize that psychotherapy is a complex endeavor and that important factors contribute to ethical and effective implementation of all treatments. Several of these, including informed consent, patient characteristics and patient-therapist relationship factors (also known as "common factors") along with therapist competence and cultural, diversity, and socio-economic and demographic vulnerability issues and applicability are discussed in the original guideline document.

Implementation Tools

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Guideline Development Panel for the Treatment of PTSD in Adults. Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults. Washington (DC): American Psychological Association; 2017 Feb 24. 119 p. [148 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Feb 24

Guideline Developer(s)

American Psychological Association - Professional Association

Source(s) of Funding

This guideline was developed with financial support from the American Psychological Association (APA).

Guideline Committee

American Psychological Association (APA) Posttraumatic Stress Disorder (PTSD) Guideline Development Panel (GDP)

Composition of Group That Authored the Guideline

Panel Members: Christine A. Courtois (*Chair*); Jeffrey Sonis (*Vice-Chair*); Laura S. Brown; Joan Cook; John A. Fairbank; Matthew Friedman; Joseph P. Gone; Russell Jones; Annette La Greca; Thomas Mellman; John Roberts; Priscilla Schulz

American Psychological Association (APA) Guidelines Staff: Lynn F. Bufka; Raquel Halfond; Howard Kurtzman

Financial Disclosures/Conflicts of Interest

Conflicts of Interest

Prior to final appointment to the panel, candidates completed a conflict of interest (COI) form that was then reviewed by members of the Advisory Steering Committee or the American Psychological Association (APA) staff to ensure there were no identified conflicts that would prohibit participation, with the understanding that some "adversarial conflict" representing different points of views was to be expected and encouraged in this process. While intellectual affiliations were expected, no panel members had been singularly identified with particular approaches to intervention nor had significant known financial conflicts. Once the panel was formed, all panel members completed an educational module on COI that underscored the importance of identifying and managing any potential conflicts, both financial and intellectual. The APA COI policy and disclosure form are included in the appendix of the original guideline document.

All panel members and staff affiliated with development of the PTSD clinical practice guideline (CPG) updated their COI form on an annual basis and were asked to provide more timely updates if changes in their disclosures were perceived to be relevant to the development of the guideline. All were asked to disclose all potential COI with the understanding that these would be reviewed and evaluated and a decision would be made regarding how to manage identified conflicts. Conflicts of interest included not only possibilities for financial or professional gain but also strong intellectual viewpoints that might then limit someone from objectively reviewing the evidence. Emphasis was placed on disclosing all potential conflicts and allowing the staff and chair (or other appropriate entity in the case of the chair) to review the disclosures and determine whether or not such information could reasonably be construed as to be a source of possible influence on the guideline development process. Furthermore, upon first joining the initiative and at the initial face to face meeting, panel members were asked to verbalize their conflicts so all present would be familiar with the diversity of perspectives and range of possible influences. This practice continued at subsequent face-to-face meetings.

Lastly, the developers of the systematic review (SR) also had their own COI policy and disclosure. While the SR was completed before the panel was formed, the Panel appreciated that the SR team also had a process to disclose and manage potential COI.

All authors were required to disclose their intellectual interests, financial and professional interests, interests related to APA, and other relevant interests. They were also required to disclose interests of family members, defined as "a spouse, domestic partner, parent, child, or other relative with whom [they] have a comparably close tie." Authors disclosed the following potential COI: scientific/educational/professional communications, communications to a general audience, roles at APA or other organizations, relevant honoraria, endorsements, research funding or royalties, payment for services or training, and serving as expert witnesses. None of the reported potential conflicts of interest precluded a nominated candidate from serving on the guideline development panel (GDP). Excluding all GDP candidates with any potential or identified COIs runs the risks of excluding the level and type of expertise needed.

There is growing recognition that financial relations to the pharmaceutical industry threaten the integrity of research and of CPGs. However, the issue is still contentious, and exclusion of all potential GDP members with such conflicts may itself be seen as biased against pharmacological treatments or particular medical specialties. Similarly, experts with respect to psychotherapy tend to have intellectual passions for specific types of psychosocial interventions that also constitute potential conflicts. Yet, such individuals may be difficult to replace because of their unique insights, as well as their status in the eyes of key stakeholders. Hence, rather than exclude topic experts and risk minimizing expertise, APA follows the principle of adversarial collaboration in which competing interests are balanced on panels and committees, rather than avoided. This approach is also used by other leading developer of CPGs, such as the American College of Cardiology Foundation/American Heart Association (ACCF/AHA) task force.

The APA COI policy and disclosure form can be found in Appendix J (see the "Availability of Companion Documents" field) along with a summary of panel member disclosures at the end of the original guideline document.

Conflict of interest forms for all authors are available by request for public review.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the American Psychological Association Web site .

Availability of Companion Documents

The following are available:

Jonas DE, Cusack K, Forneris CA, Wilkins TM, Sonis J, Middleton JC, Feltner C, Meredith D, Cavanaugh J, Brownley KA, Olmsted KR, Greenblatt A, Weil A, Gaynes BN. Pyschological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD). Comparative Effectiveness Review No. 92. AHRQ Publication No. 13-EHC011-EF. Rockville (MD): Agency for Healthcare Research and Quality; 2013 Apr. 760 p. Available from the National Center for Biotechnology Information Web site .

Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults. Appendices. Washington (DC): American Psychological Association; 2017 Feb. 556 p. Available from the American Psychological Association Web site .

Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD). Resources. Washington (DC): American Psychological Association. Available from the American Psychological Association Web site .

Placing clinical practice guidelines in context. Washington (DC): American Psychological Association; 2017 Jul 31. Available from the American Psychological Association Web site .

Patient Resources

The following is available:

PTSD: for patients and families. [internet]. Washington (DC): American Psychological Association; 2017 Jul 31. Available from the American Psychological Association Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

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